MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 7

CERTIFICATE OF DEATH

07856

Reg. Diat. No. 61

1. PLACE OF DEATH:
County: Caroline
City or town: Near Greensboro
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Caroline
City or town: Near Greensboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Joyce Ann Anthony

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	S.

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 14 1945

8. AGE: Years | Months | Days: 22 | If less than one day: hrs. min.

9. Birthplace: Near Greensboro Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Elwood Anthony
13. Birthplace: Maryland

MOTHER
14. Maiden name: Florence Harris
15. Birthplace: Maryland

16. Informant: Elwood Anthony Father
Address: Denton Rfd. R-

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-23-45 (month) (day) (year)
Cemetery or crematory: Pines Grove Cemetery
Location: Near Denton

18. Funeral director: J. Virgil Mason & Son
Address: Denton Rfd.

19. Aug 22 1945 L. MacLynn Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 22 1945 at 6 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 21 1945 to Aug 22 1945 and that I last saw her alive on Aug 21 1945

Immediate cause of death	DURATION
Peritonitis	4 da
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Charles H. Hemsley M.D.
M. D. or other
Address: Greensboro Md. Date signed Aug 22 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information requested. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for addition of usual residence of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

07857

FILM No. G 98 OCT 4 1945

Reg. Diat. No. 64

1. PLACE OF DEATH:

County: Caroline

City or town: Federalsburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Full life

Hospital, institution, or street address where death occurred: R.F.D.

How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Caroline

City or town: Federalsburg, R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: John Wesley Briggs

3.(b) Social Security Number: none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

6.(b) Name of husband or wife: Ada Briggs

6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): June 28, 1878

8. AGE: Years: 67 | Months: 1 | Days: 23 | If less than one day: hrs. min.

9. Birthplace: Williamsburg Md.

(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER 12. Name: John W. Briggs

13. Birthplace: "

MOTHER 14. Maiden name: Mary Eliza Holiday

15. Birthplace: Md.

16. Informant: Allan Briggs

Address: Federalsburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 23, 1945 (month) (day) (year)

Cemetery or crematory: Shiloh Cemetery

Location: Williamsburg, Md.

18. Funeral director: Harvey Williams

Address: Federalsburg, Md.

19. August 21 1945 (Date rec'd by registrar) J. J. Farris Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/20 1945, at 4 AM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1st 1945, to Aug 20th 1945

and that I last saw h... alive on Aug 20th 1945

Immediate cause of death: Coronary Thrombosis — DURATION: 3 hrs.

Due to: Chronic myocarditis — 5 yrs.

Due to: Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank M. Anderson M.D. M. D. or other

Address: Federalsburg Md. Date signed: Sept 5 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

07858

Reg. Dist. No. 64

1. PLACE OF DEATH:

County Caroline

City or town Federalsburg

(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 years

Hospital, lostitution, or street address where death occurred:

Denton Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Caroline

City or town Federalsburg - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Houston Branch Road

(If rnral, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME William H. Briggs

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife Annie Briggs

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) December 20, 1882

8. AGE: Years	Months	Days	If less than one day
62	8	3	hrs. min.

9. Birthplace Dorchester County, Maryland

(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business House Carpenter

FATHER 12. Name John Briggs

13. Birthplace New York State

MOTHER 14. Maiden name Eliza E. Holliday

15. Birthplace Caroline County, Maryland

16. Informant William E. Briggs

Address Federalsburg, Maryland, R.F.D.

17. Burial Date thereof August 27 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Skinner's Run Cemetery

Location Near Williamsburg, Maryland

18. Funeral director J. T. Frampton and Son

Address Federalsburg, Maryland

19. August 27 1945 J. T. Frampton

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1945, at 5:10 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 22 1945, to Aug 23 1945-

and that I last saw him alive on Aug 23 1945-

Immediate cause of death	DURATION
Coronary Thrombosis	2 dy.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. E. Lemmon M.D.

M. D. or other

Address Federalsburg Md Date signed 8/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

07859

Reg. Dist. No. 60

1. PLACE OF DEATH:
County Caroline.
City or town Greensboro.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Caroline.
City or town Greensboro.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Alberta Broom.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	C.	Married.

6.(b) Name of husband or wife Samuel Broom.
6.(c) If alive, give age 78. years

7. Birth date of deceased (mo., day, yr.) Dec 18. 1872

8. AGE:

Years	Months	Days	If less than one day
72	7	20	hrs. min.

9. Birthplace Caroline Co Md.
(Town, county, and state)
10. Usual occupation Housewife.
11. Industry or business
FATHER 12. Name John Hacket.
13. Birthplace Md.
MOTHER 14. Maiden name Nuckoms.
15. Birthplace Md.
16. Informant Robert Dyer
Address Thomas And Lawsons R.1. Burial
17. (Burial, cremation, or removal. Which?) Date thereof aug 10/45.
(month) (day) (year)
Cemetery or crematory Mt Zion
Location Maydue Md.
18. Funeral director Raymond B. Rawlings.
Address Greensboro. Md.
19. 8/7/45 19 A C Smith Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/6 1945, at 19 M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to Aug 1945
and that I last saw her alive on 8/1 1945

Immediate cause of death	DURATION
Heart Failure	
Due to Organic Heart Valvular	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. D. Dehuff M. D. or other
Address Goldsboro Md. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (16)

07860

CERTIFICATE OF DEATH

Reg. Dist. No. 62

1. PLACE OF DEATH:

County: Caroline

City or town: Burrsville Neg. (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Caroline

City or town: Burrsville Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) If VETERAN, NAME WAR:

3. (a) FULL NAME: John Chance

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	married

6 (b) Name ~~of husband~~ or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 11th 1883

8. AGE:

Years	Months	Days	If less than one day
62	6	23	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: John E. Chance

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Sarah Satterfield

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Ina Chance

Address: Rd. Denton Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 8-8-45 (month) (day) (year)

Cemetery or crematory: Denton Cemetery

Location: Denton Md.

18. Funeral director: J. Virgil Wright Lowe

Address: Denton Md.

19. 8-7-1945 (Date rec'd by registrar) Wm O George Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 4 1945, at 2A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4 1945, to Aug 4 1945, and that I last saw him alive on Aug 3 1945

Immediate cause of death	DURATION
Due to Tuberculosis & Pleurisy	7yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wm O George (M. D. or other)

Address: Denton Date signed: 8/7/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

07861

CERTIFICATE OF DEATH

Reg. Dist. No. 61

1. PLACE OF DEATH:

County: Caroline

City or town: Near Greensboro

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Caroline

City or town: Greensboro, R. 3, Md. Rfd.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John Clarence Ireland

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	married

6.(b) Name of husband or wife: Della Greenley Ireland

B.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): Aug. 20th 1894

8. AGE: Years	Months	Days	If less than one day
51	5	6	....hrs. ....min.

9. Birthplace: Caroline County, Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: John Ireland

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Sarah Parks

15. Birthplace: Maryland

16. Informant: Mrs. Della Ireland (wife)

Address: 1 Denton, Md. Rfd.

17. Burial (Burial, cremation, or removal, Which?) Date thereof 8-28-45 (month) (day) (year)

Cemetery or crematory: Greensboro Cemetery

Location: Greensboro, Md.

18. Funeral director: J. Virgil Medford

Address: Denton, Md.

19. Aug. 27 1945 (Date rec'd by registrar) L. M. Peyton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 25 1945, at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 15 1945 to Aug. 25 1945

and that I last saw him alive on Aug. 24 1945

Immediate cause of death	DURATION
Coronary Thrombosis	10 da.
Due to	
Due to	
Other conditions Chronic Bronchitis	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Clark X Hovenden M.D.

M. D. or other

Address: Greensboro Md. Date signed 8/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-2)

07862

CERTIFICATE OF DEATH

★ Reg. Dist. No. 64

1. PLACE OF DEATH:

County Caroline

City or town Federalsburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:
North Main Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Caroline

City or town Federalsburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. North Main Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Hilda M. Jarman

3. (b) Social Security Number 214-22-6220

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Harry W. Jarman

6.(c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) August 6, 1906

8. AGE: Years	Months	Days	If less than one day
39	0	9	...hrs. ...min.

9. Birthplace Federalsburg, Maryland
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER
12. Name Thomas S. McCrea

13. Birthplace Federalsburg, Maryland

MOTHER
14. Maiden name Mary V. Wells

15. Birthplace Galestown, Maryland

16. Informant Mrs. Leonard Travers

Address Federalsburg, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 18 1945 (month) (day) (year)

Cemetery or crematory Hill Crest Cemetery

Location Federalsburg, Maryland

18. Funeral director J. J. Frampton and Son

Address Federalsburg, Maryland

19. August 18 1945 (Date rec'd by registrar) S. S. Frampton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1945, at 9:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to Aug 15 1945, and that I last saw h.e.r. alive on Aug 15th 1945.

Immediate cause of death Carcinoma of cervix, a generalized infection

DURATION 7½ months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank M. Anderson M.D.
M. D. or other

Address Federalsburg, Md. Date signed 8/18/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07863

Reg. Dist. No. 60

1. PLACE OF DEATH:

County: Caroline

City or town: Henderson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Caroline

City or town: Henderson
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Sallie A, Meredith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: John W, Meredith

6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): Sept 5.1877

8. AGE: Years	Months	Days	If less than one day
68	11	22	hrs. min.

9. Birthplace: Templeville Caroline Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: William Cahall
13. Birthplace: Md,

MOTHER
14. Maiden name: Sofa Steel
15. Birthplace: Md,

16. Informant: Mrs, Pearl Jones
Address: Henderson. Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug, 31.1945 (month) (day) (year)
Cemetery or crematory: Greensboro
Location: Greensboro, Md,

18. Funeral director: Raymond B, Rawlings
Address: Greensboro, Md,

19. Aug 29 1945 (Date rec'd by registrar) A C Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 27 1945 at 5.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/27 1945 to 8/27 1945 and that I last saw her alive on 8/27 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2
Due to Hypertension	years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Goldsboro md Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

07864

Reg. Diat. No. 61

1. PLACE OF DEATH:
County: Caroline
City or town: Greensboro
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Caroline
City or town: Greensboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Emma A. Pippin

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Carroll Pippin
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 20, 1859

8. AGE:

Years	Months	Days	If less than one day
86	6	4	..... hrs. ..... min.

9. Birthplace: Greensboro Caroline Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: James Causey
13. Birthplace: Md.
MOTHER 14. Maiden name: Emma Davis
15. Birthplace: Md.
18. Informant: Mac. Pippin
Address: Greensboro Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: aug. 26. 1945 (month) (day) (year)
Cemetery or crematory: Greensboro
Location: Greensboro Md.
18. Funeral director: Raymond B. Rawlings
Address: Greensboro. Md.
19. Aug 25 1945 (Date rec'd by registrar) L. Mac Pippin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 24 1945 at 8:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3 1945, to Aug. 24 1945
and that I last saw her alive on Aug. 24 1945

Immediate cause of death	DURATION
General Cerebral Arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Clark H. Poisal M.D.
M. D. or other
Address: Greensboro Md. Date signed 8/25/45

M

1

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.